STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345234	A. BUILDING _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON HEALTH AND REHAB CENTER	1555 WILLIS AVENUE LUMBERTON, NC 28358

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F 000	INITIAL COMMENTS The survey team entered the facility on 3/10/21 to conduct an unannounced complaint investigation. Additional information was obtained offsite on 3/11/21 and 3/12/21. Therefore, the exit date was 3/12/21. 1 of the 8 complaint allegations was substantiated resulting in deficiencies. Event ID #JGX511.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		4/3/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/02/2021

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F 580	Continued From page 1 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, family interview, staff interview the facility failed to notify the interested family of a significant change in condition and changes to medications for 1 of 1 sampled resident (Resident #2). The findings included: Resident #2 was admitted to the facility on 7/25/17 with diagnosis that included Alzheimer's, major depressive disorder, anxiety disorder, and abnormality of gait and mobility. Resident #2 expired on 1/13/21. A quarterly Minimum Data Set (MDS) assessment dated 11/1/20 indicated Resident #2 was independent with activities of daily living	F 580	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is solely prepared because it is required by the provision of the Federal and State Law. Resident #2 was admitted to the facility on 7/25/2017 with diagnosis that included Alzheimer's, major depressive disorder, anxiety disorder, and abnormality of gait and mobility. She was diagnosed with COVID-19 on 12/23/2020. She was seen by the physician on 1/4/2021 for changes and received new orders to discontinue	

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F 580	Continued From page 2 (ADL) to include eating, walking, bed mobility and transfers. The MDS further indicated Resident #2 ambulated by use of a walker. Resident #2 was coded as being severely cognitively impaired. Resident #2 was diagnosed with COVID-19 on 12/23/21. Review of physician progress note dated 12/24/20 revealed a history of present illness that stated Resident #2 had a history of weight loss, poor appetite and was diagnosed with COVID. The note further revealed an assessment and plan stated continue to monitor Resident #2's respiratory status and oral intake. Resident #2 was at very high risk for worsening failure to thrive symptoms. Review of nursing notes dated 12/25/21 at 1:18pm revealed Resident #2 remained continent of bowel and bladder and ambulated to bathroom using a walker. Nursing notes dated 12/30/20 at 2:24pm stated Resident #2 was continent with incontinent episodes and she was ambulatory. Physician progress note dated 1/4/21 revealed a history of present illness that stated staff requested evaluation because Resident #2 had tested positive for COVID - 19 on 12/23/20. Resident #2 was not eating, not drinking and was extremely confused. The note continued with prior to testing positive for COVID -19 she was ambulatory, feeding herself, pleasantly confused and able to interact with staff and family. Resident #2 was also incontinent of bowl and bladder. The progress note stated Resident #2 continued to	F 580	Depakote and Lexapro and to start Morphine 5mg every hour as needed and Ativan 0.5mg every 4 hours as needed subcutaneously in case she was to start the end of life process. The order changes and change in status were not communicated to the responsible party at that time. The resident was seen by the physician again on 1/11/21. The responsible party was notified of resident's condition at that time. On 1/12/21, the resident's current status and all orders were reviewed with the responsible party. The resident expired on 1/13/21. All residents residing in the facility have the potential to be affected by failing to notify the resident/responsible party of changes. A review of SBARS and new orders for current residents from 3/15/21-4/1/21 was completed by the Director of Nursing for MD and RP notifications. The audit was completed by 4/1/21 and has been implemented as part of clinical start up five times a week. Updates were given to the Responsible Party if indicated from the audit. Current licensed nursing staff will be in-serviced by the Director of Nursing on utilization of the SBAR tool and its completion with notification of MD and Responsible party as well as for any changes in orders. This education will be completed by 4/3/2021. The Director of Nursing, Unit Manager, or assigned licensed nurse will review	

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F 580	Continued From page 3	F 580	SBARs and new orders to ensure notification to Responsible party occurred. This will be completed as part of the clinical start up five times weekly for 12 weeks. The results will be reviewed in QAPI for 3 months. Date of Compliance: 4/3/2021 Person Responsible for Plan of Correction: Christie Russell, RN/Director of Nursing	

decline and she had not been improving and that she may continue to progress in the end of life process. The note continued that Resident #2 would start Morphine 5 milligrams (mg) every hour as needed and Ativan 0.5mg every 4 hours as needed subcutaneously in case Resident #2 was to start the end of life process and the staff to be able to give her comfort. Depakote and Lexapro were discontinued as they were not contributing to her quality of life.

Review of nursing note dated 1/4/21 at 1:35am stated Resident #2 was continent of bowel and bladder with incontinent episodes noted since COVID.

Review of Resident #2's nursing note dated 1/4/21 at 12:50pm written by Nurse #1 revealed the medical doctor discontinued routine medications.

Review of nursing notes 1/5/21 through 1/6/21 indicated Resident #2 refused meals, was spoon fed, had poor appetite and refused to be fed by staff.

Review of Physician progress note dated 1/7/21 revealed Resident #2 had a recent diagnosis of COVID on 12/23/20 and had been exhibiting a decline since then. The note continued staff stated Resident #2 seemed a little better as she was moving around in bed and drinking some. The diagnosis, assessment and plan stated Resident #2 was not a good candidate for intravenous (IV) fluid therapy because she would not leave it in so fluids would continue to be encouraged.

Review of nursing notes dated 1/7/21 indicated

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F 580	Continued From page 4	F 580		

Resident #2 required extensive assistance for ADL, incontinent of bowl and bladder, refused all meals and would not open her mouth to eat.

Review of nursing notes dated 1/8/21 revealed Resident #2 was combative at times, required extensive assistance with ADL, refused all meals, and would not allow staff to feed her, and had low mumbled speech.

Review of nursing notes dated 1/10/21 indicated Resident #2 refused to eat when assisted, would take a few sips of liquid to drink, required extensive assistance for ADL. Resident #2 was given morphine with relief noted.

Review of physician progress note dated 1/11/21 sated Resident #2 continued to decline and progress in the end of life process. She was not able to drink or eat. Staff was reporting that she was pocketing the food. Nursing reported that Resident #2 had required morphine and Ativan to achieve goal of comfort. The diagnosis, assessment and plan revealed, Resident #2 had not been able to improve. She was transitioning to the end of her life. The note continued that the physician had discussed the case with the supervisor and the Director of Nursing (DON) and her family would be contacted so they can spend some time with her.

Review of nursing note dated 1/11/21 at 1:25pm stated family informed of resident's condition and compassionate care visit offered.

Review of concern form dated 1/12/21 filed by Resident #2's Responsible party identified concerns that included she was upset of Resident #2's condition. She reported that she had been

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being told Resident #2 was fine until yesterday (1/11/21) when she was called to come in for a compassionate care visit and stated she was now being told that Resident #2 hadn't been eating for the last ten days. The action taken by the facility was informing the responsible party of Resident #2's consumption of supplements and the resident had seemed to be consuming until Saturday. Uncertainty with COVID and the potential for rapid change in status was further discussed with the responsible party. Resident #2's orders were reviewed.

Interview with Resident #2's family member on 3/10/21 at 1:43pm revealed she was the primary contact for Resident #2. She stated the she wasn't made aware that Resident #2 had stopped eating. She indicated she contacted the facility often and was told the resident was doing fine. She stated she did not know the resident had stopped eating and was put on medication for comfort care until she received a phone call on 1/11/21 stating they could come in to have compassionate care visits.

Interview with Nurse #1 on 3/10/21 at 2:50pm revealed nursing staff was to notify the family changes in the resident to include declines in activities of daily living. The notification would be documented in a nursing note. She stated she had daily contact with Resident #2's family. She stated the family would also call the facility and ask about how the resident was doing. She stated she had let the family know the resident wasn't eating well.

Interview with Nurse #1 on 3/11/21 at 2:00pm revealed she had written the nursing note dated 1/4/21 that gave Resident #2 new orders. She

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F 580	Continued From page 6	F 580		

stated the order discontinued Resident #2's routine meds and started comfort measures. She stated if she had called the family she would have documented the notification the nursing note. She further stated that it was normally the nurses that took the order that would call the family. She was unaware if the assigned unit manager had contacted the family regarding Resident #2's medication change. She indicated she had not documented in her note that the family was contacted regarding the medication change.

Interview with Nurse #2 on 3/11/21 at 1:51pm revealed she had written the nurse note dated 1/7/21. She stated she recalled the resident doing for herself and was requiring extensive assistance with all of her ADL and she documented the assistance she required. Nurse #2 revealed that in the instance a resident had a decline she would notify the Doctor and the resident's family and a note would have been made to reflect the notification. She stated she was under the impression that everyone was aware of Resident #2 decline as she was made aware during change of shift meetings.

Interview with Nurse #4 on 3/11/21 a 2:39pm revealed Resident #2 required more assistance following her COVID diagnosis. She sated Resident #2 did not need assistance with ADL before COVID.

Interview with the Director of Nursing (DON) on 3/10/21 at 2:09pm revealed if a resident had issues surrounding nutrition more than once a day or issues that lead to weight loss they would notify the family and it would be documented in the nursing note.

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F 580	Continued From page 7 Additional interview with the DON on 3/12/21 at 11:37pm revealed nursing staff was responsible for communicating changes to residents' condition to the physician and to the responsible party. She indicated that she did not see any documentation to support notification to Resident #2's responsible party concerning significant change in condition or notification of changes to medications. She further indicated the decline would have to be consistent to be communicated to the family as a change in condition. She stated Resident #2 had periods where she was feeling better. The resident decline in ADL was not consistent as she had days in which she did better. She indicated the order for comfort care was not initiated until 1/11/21 when the physician wrote the order. The family was made aware on the date the order was written and visitation was offered. Interview with the Administrator on 3/12/21 at 12:55pm revealed responsible parties should be notified of a resident's change in eating, mobility and changes to medications.	F 580		